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ABSTRACT

The Family to Family program provides relief to families with emotionally impaired children through regular out-of-home respite care with host families. The overall goal of the program is to keep families with seriously emotionally impaired children intact, thus avoiding out-of-home placement. The program therefore involves, in addition to establishing organizational, technical, and material resources necessary to implementing the program, three major activities: (1) identifying suitable consumer families, (2) identifying suitable host families, and (3) providing ongoing support to both consumer and host families. This report comments briefly on each of these facets. It assesses parental attitudes towards their Family to Family experience and the functioning of their emotionally impaired children. It includes various problems faced in the start-up; recruitment of consumers; identification of host families; provision of support services; and retention issues. The support provided to the consumer and host families was found to be appropriate. Efforts of the staff to support the families through meetings, personal contacts, and a program newsletter were deemed suitable if not exemplary. Staff progress notes and observations indicate a positive program evaluation by the consumer and host families, but a more authoritative answer will have to await data in the final report. (JDM)

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FIRST YEAR EVALUATION REPORT

FAMILY TO FAMILY PROGRAM

February 1998

Luellen Ramey, Ph.D and David P. Meyer, Ph.D.

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First Year Evaluation Report
February 1998

Luellen Ramey, Ph.D. and David P. Meyer, Ph.D.

Introduction and Scope of Report

This evaluation report covers the period from the funding in January 1997, into February 1998, including various problems faced in start-up, recruitment of consumers, identification of host families, provision of support services and retention/suitability issues. We will describe the consumers in terms of entry characteristics as measured by three indices: case notes, pre-placement forms, and Child and Adolescent Functional Assessment Scale (CAFAS) levels. These sources will provide us with data to assess two of the four variables outlined in the "Evaluation Plan for Family to Family Program" (Ramey and Meyer, 1997)

1. Parental attitudes toward Family to Family experience (Family to Family Questionnaire - pre-placement)
2. Functioning of the emotionally impaired children (CAFAS and case notes)
3. Family cohesion (FACES II)
4. Family adaptability (FACES II)

Family cohesion and adaptability scores will be addressed in a later report, when post treatment FACES II scores become available, allowing for analysis of difference scores. It should be noted that in one departure from the Evaluation Plan, the Family to Family Questionnaire is being administered before placement, at 6 month intervals and post placement, rather than post placement only. The staff and evaluators agree that obtaining pre, progress, and post difference scores is worth the slight risk of familiarity contamination through multiple administrations of the instrument. We judge the typically lengthy involvement in the program and thus the 6 months time lapse between pre, progress, and post testing to be sufficient to all but eliminate pretest influence on post-testing.

Nature and Intent of Family to Family Program

The Family to Family Program falls under the broad category of respite care, providing relief to 25 families with emotionally impaired children through regular out-of-home

respite care with host families. The objectives are to offer relief and rejuvenation to comsumer families, to increase social connectedness of consumer families and to enhance their parenting and child management skills. The overall goal of the program is to keep families with seriously emotionally impaired children intact, thus avoiding out-of-home placement. (Oakland County Community Mental Health Services Family to Family Proposal, 1996). The program therefore involves, in addition to establishing organizational, technical and material resources necessary to implementing the program, three major activities:

1. Identifying suitable consumer families
2. Identifying suitable host families
3. Providing ongoing support to both consumer and host families

This report will comment briefly on each of these facets of the program in addition to the consumer measures listed above.

Establishing Organizational, Technical and Material Resources

Oakland County Comunity Mental Health (OCCMH) has clearly fulfilled its obligations in this respect. Under the energetic leadership of Michelle Quarton, who was largely responsible for developing the Family to Family Program proposal, a qualified project coordinator, Christine Miller, was identified and employed during the early stages of the program. Expertise and material resources in the form of various OCCMH specialists, space, secretarial assistance, supplies, equipment and funding have all been provided to bring the project into reality. No project start-up is without problems, but the Family to Family Program has attacked various staff and resource problems with professional determination and appropriate deliberation and speed.

Recruitment of Suitable Consumer Families

The program goal is to serve 25 families with emotionally impaired children. Due to the nature of the program, which involves matching families, the recruitment of consumer and host families must occur somewhat simultaneously, lest recruited consumer families have to wait an excessive amount of time for services to begin. Moreover, because inevitably some families would leave the program due to various life circumstances, causing the number of consumer families to fluctuate, the number of 25 is taken as an average participation approximation once the program is in full swing. The principle means of recruiting suitable consumers has been through referrals from OCCMH clinicians. The Family to Family program has been discussed in group meetings, individually, with supervisors and various descriptive materials have been sent to the clinicians. As of early February, 1998, eleven months after program initiation, and perhaps eight months after recritment efforts began in earnest, 21 referrals of consumer families have resulted; 7 terminations have occurred with 14 consumer families participating as of early February, 1998. The first families were enrolled in June and enrollments and recruitment continue until the present. The average length of stay for those who have thus far left the program was just under 4 months. Of those leaving the program, 4 moved away, one family terminated due to

giving up their parental rights, another family was determined inappropriate for the program, and in one case the parent didn't evaluate the program as flexible enough to meet her needs.

From this information it appears that referrals are suitable, but lacking in numbers. The staff notes that there are two geographically separate clinical systems in the county, north and south, and that most referrals come from the south system. Differences in socioeconomic factors and culture, as well as supervision may be at work, according to the staff. Of some 30 clinicians who might potentially refer families, just 5 or 6 have made almost all referrals. The staff has undertaken various steps to increase the flow of referrals to the program: review of all emotionally impaired client files, contacting clinicians, making pitches at general and subgroup staff meetings. There is hope that the goal of 25 enrolled consumer families will be attained with increased publicity and personal contact with clinicians. But the possibility remains that 25 is an unrealistic figure - the caseload of current emotionally impaired consumers (all have been reviewed) simply may not contain 25 suitable for this particular program. In any case, the staff appears to have taken all reasonable, proactive steps to insure consumer flow into the program. We recommend "more of the same;" they perhaps can explore the north-south clinical system gap; focus on the non-referring clinicians and examine the possibility of extending recruitment efforts to other service agencies.

Recruitment of Suitable Host Families

This has typically been a problem in respite programs but appears not to be in this one. Every consumer family has been provided a suitable host family, some better than others, but all judged satisfactory, and no undo delays in locating host families have occured. In just one current case, a marginally suitable host family fills in while recruitment of a more suitable family continues. About 40% of the consumer families have located their own hosts, and the stipend paid seems to be at a level which attracts appropriate host families, though other motivations contribute as well. We evaluate this activity as being carried out in a satisfactory manner.

Providing Ongoing Support for Consumer and Host Families

The Family to Family staff has engaged in both individual family and group oriented information and discussion sessions. Gathering numbers of families together for these sessions has proven difficult due to the varied family schedules. However, the staff has maintained close individual contact with all consumer and host famillies to answer questions, troubleshoot problems and offer, where necessary, complimentary services. The staff displays detailed knowledge of the consumer families and familiarity with the situational variables and suitable matching of host families. In addition, the Program Coordinator edits a newsletter which informs participating families of various educational, recreational and support activities and communicates Family to Family information. We evaluate the training and support of families participating in the program as appropriate and sufficient to meet their needs.

Consumer and Family of Consumer Characteristics

The staff has gathered a vast amount of data on consumers and their familes which will ultimately give a clear clinical picture of the program participants and it is expected will contribute to our understanding of any gains in individual and family functioning which may reasonably be attributed to the program interventions. In this report we will focus upon functional (and to a lesser extent, demographic) characteristics at entry to the program. The figures given will include all program participants, including those terminated regardless of the brevity of treatment. In later reporting, where pre and post (FACES II) measures are considered, a minimum standard treatment duration will be applied. The mean age of children who have participated in the Family to Family Program is 10.5 with a range of 5 to 16. There have been 17 males and 4 females.

Pre-placement questonnaire. This instrument is a nonstandardized, staff-developed, ten item, 4 point Likert type scale designed to examine the following factors:

- ability to maintain child at home (Q1)
- stress level for self (Q2) and family (Q3)
- time available for self (Q4) other children (Q5) spouse (Q6)and friends (Q7)
- ease of childcare arrangements (Q8)
- sense of control over one's life (Q9)
- adequacy of outside support (Q10)

The instrument is easily administered, brief, easy to score and taps into construct validity by asking questions intimately connected to the goals of the program, the quality of the parents' family/personal life and resources available to the family. The questionaire is arranged so that scores of 1 indicate high function /lack of problems, and scores of 4 indicate poor functioning and the presence of problems. Thus scores below 2.5 indicate lack of problems and those above indicate problem areas. The grand mean of all questions on this instrument of all 20 families enrolled in the program was 3.18, indicative of low function and the presence of problems in the service group. The range of scores by family was 1.55 to 4.0. However, 14 of the 20 families had scores of 3.0 or higher. Only one set of parents scored below 2.5, and that score, 1.55, seems to indicate high coping skills and a lack of problems identified in the questionaire.

When the mean scores are analyzed by question, the rank order of problem areas are:

Having time for spouse/significant other (mean = 3.61)
Having time for friends (mean = 3.5)
Having time for self (mean = 3.45)
Difficulty in child care arrangements (mean = 3.38)
Life control (mean = 3.24)
Outside support (mean =3.18)
Family stress level (mean = 3.13)
Personal stress level (mean =3.01)

The only two items rated under 3 were: "I have enough time for other members of the family" (mean = 2.88) and "I feel I can continue to maintain my child at home" (mean = 2.44)

The service sample can with but one exception be said to be experiencing significant difficulties in the areas of time constraints interfering with personal, social and spousal interaction, child care, outside supports, a sense of low life control, and familial/personal stress. The relatively low score on the question dealing with perceived ability to maintain the child at home probably reflects the commitment and hopefulness of the consumer's parents.

Functioning of the Emotionally Impaired Children

The Child and Adolescent Functional Assessment Scale (CAFAS) serves as the primary source of determining the program consumer's functioning level and problem areas. The CAFAS yields ten scores on five scales from which a total score is derived. Each scale may yield 4 scores: 0 (minimal or no impairment); 10 (mild impairment); 20 (moderate impairment) and 30 (severe impairment). These scores are derived through multiple descriptions on scales labeled:

- Role performance - subscales are School/Work, Home, and Community
- Behavior Toward Others
- Moods/Self-Harm - subscales are Moods/Emotions and Self-Harmful Behavior
- Substance Abuse
- Thinking

In areas with subscales, the highest subscale is the score used for the diagnostic 5 scale score; these are added to yield a Total Youth Score:

- 0 - no impairment or dysfunction. Preventive intervention if child is at risk.
- 10 - youth may benefit from some level of intervention or prevention efforts
- 20-30 - youth can likely be treated on outpatient basis
- 40-60 - may need services beyond weekly outpatient visits, but probably not residential treatment unless alternatives are not available. Risk factors may intensify need for service.
- 70-80 - may need intensive therapeutic program depending on resources available and risk factors.
- 90 or higher - restrictive or supervised living situation may be needed depending on resources available in the community and youth's risk behaviors.

In addition, an 8 scale score can be obtained by adding all eight scores, 5 of which are subscale scores. For the purposes of this report, only 5 scale scores will be utilized.

In addition the CAFAS may be scored for Primary and Other Caregiver resources in two ways: Material Needs and Family Social Support. There are four risk behaviors

- Self-Harm
- Aggression

- Sexual Behavior
- Firesetting

These risk behaviors are seen as exacerbating elements which may indicate more intensive levels of intervention. These risk factors were assessed by the clinicians in 16 of the 20 cases under review.

CAFAS scale scores were available for 20 of the 21 cases. The mean scores and Impairment levels for each of the scales and subscales as well as 5 scale Total Youth scores are given in the table below.

		Impairment Levels		
Scales (and Subscales)	MeanScore	#Severe	#Moderate	# Minimum
Role Performance	23	12	3	5
School/Work	20.5	7	7	6
Home	18.5	9	3	8
Community	7	0	5	15
Behavior Toward Others	20	6	8	6
Moods/Self-Harm	15.5	3	7	10
Moods/Emotions	14.5	3	5	12
Self-Harm	4.5	1	1	18
Substance Abuse	0.5	0	0	20
Thinking	5.5	1	0	19
Total Youth 5 scale score	64.5	8	7	5

As can be seen from the table above, the mean CAFAS score indicates a consumer sample of moderately dysfunctional children on average. There is, however, a large number (40%) of the group who are severely dysfunctional. A smaller proportion (20%) fall in the minimally dysfunctional category. While a number of interpretations of these data are possible, it seems to the evaluators that the Family to Family Program may serve a number of purposes, both preventive and remedial, thus appropriately may encompass a wide range of dysfunction in its service population.

CAFAS risk factors were present in 9 of the 16 cases where they were evaluated, the most common being aggression (6 cases); each of the 3 other categories, self-harm, sexual behavior and firesetting tallied one case each. Seven cases were diagnosed ADHD and there were four anger disorder diagnoses among the 12 cases where clinical diagnoses were available.

The primary family's ability to provide materially and socially was also rated in 18 of the cases (0-10 = minimal, 10-20 = moderate, 30 = severe). The mean material support score was 5.0, indicative of few problems in this area; the familial/social rating averaged 13.9, indicating mild to moderate problems in the familial/social sphere at home. Of the 18 families rated for the familial/social factor, two were judged severe, seven were rated moderate, five were considered mild, and four had no impairment in this area.

Summary and Recommendations

Evaluation of both formal, scorable reports and less formal case notes, reports and observations have provided a wide range of data which may serve to give an overall picture of the Family to Family Program. The Oakland County Community Mental Health agency has staffed and supported the program appropriately. The three major program activities: identifying suitable consumer families, identifying suitable host families and providing support to both groups, were reviewed. The goal of providing service to 25 consumers has not been met and continues to prove difficult to attain. The staff has made reasonable efforts to locate appropriate consumers and to obtain referrals from OCCMH clinicians. We recommend increased efforts to educate and inform not only OCCMH clinicians but also those of other family service agencies who might become a source of referrals to the program. The current level of consumer enrollment is assessed less than ideal at 14, and assuming there are families in Oakland County who are well matched to the program, deprives them of its benefits. Finding host families for the consumers has been difficult but has been accomplished satisfactorily. In addition, the support provided to consumers, their families and the host families seems both appropriate and timely. The staff has intervened to find a more suitable host family where necessary and to educate and provide assistance to various program constituents. Moreover, the efforts of the staff to support program consumers and families through meetings, personal contacts and a program newsletter are deemed suitable and even exemplary.

The case notes and CAFAS scores reveal a consumer group which appears appropriate for the program. On the average they suffer moderate dysfunction, though a significant group (40%) scored in the "serious" dysfunction category. The two scales most commonly elevated were Role Performance and Behavior Toward Others (23 and 20 respectively), considered moderately dysfunctional. The Moods and Self-harm scale was next at 15.5, heavily loaded toward Moods (14.5). These issues are supported by clinicians' notes and DSM IV diagnoses of ADHD (most common) and ODD or anger disorders. Staff progress notes and observations indicate that the program is evaluated positively by consumers, consumer parents and host families as well. From these observations we infer improved consumer family relations, increased parental time for self, spouse and friends and improved consumer functioning. These are of course tentative and clinical observations, not supported by hard data, nor have a number of consumers participated long enough for full treatment effects to have occurred. The more authoratative answer to questions about consumer functioning and the impact of the Family to Family Program on consumer families will have to await the analysis of a variety of data in the final project report.